

# Emergency Medical Technician License Renewal Application

## Idaho Emergency Medical Services Bureau

Send completed form to Idaho EMS Bureau, PO Box 83720, Boise, ID 83720-0036 or Fax to 208-334-4015



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

**Completion checklist:** ☐ License Holder Signature ☐ Affiliating Agency Authorized Signature  
☐ Continuing Education Record completed and signed ☐ Skills Verification completed and signed

Name \_\_\_\_\_  
Last Name First Name Middle Name/Initial  
Idaho EMS License # \_\_\_\_\_ or Social Security # \_\_\_\_\_  
Circle the highest level of education: GED High School Diploma College: 1 2 3 4 5 6 7 8 Gender ☐ F ☐ M  
Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_  
E-Mail Address \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
Street City State Zip County

### Affiliation:

Qualifying Agency of Affiliation \_\_\_\_\_ Agency License # \_\_\_\_\_

Agency Authorized Signature \_\_\_\_\_  
Signature Printed Name

Career status for qualifying agency: Volunteer ☐ True ☐ Compensated Career ☐ Full Time ☐ Part Time

List all agency or hospital affiliations or associations (Use additional form if necessary.)

Agency/Hospital \_\_\_\_\_ Volunteer ☐ True ☐ Compensated Career ☐ Full Time ☐ Part Time

Agency/Hospital \_\_\_\_\_ Volunteer ☐ True ☐ Compensated Career ☐ Full Time ☐ Part Time

Agency/Hospital \_\_\_\_\_ Volunteer ☐ True ☐ Compensated Career ☐ Full Time ☐ Part Time

*I am also an Idaho licensed/certified health care provider as a(n)* (circle all that apply): MD / DO / PA / RN / RT / other (please specify) \_\_\_\_\_

*Have you been charged with or convicted of a felony that you have not previously disclosed to the EMS Bureau?* ☐ Yes ☐ No

If yes please explain: \_\_\_\_\_

*Has an EMS agency taken any adverse action against you that you have not previously disclosed to the EMS Bureau?* ☐ Yes ☐ No

If yes, please explain: \_\_\_\_\_

(Separate sheets may be attached)

### Signature:

I hereby affirm the information herein is true and correct, and that I meet all requirements for EMS licensure as established by the State of Idaho.

Signature of Candidate \_\_\_\_\_ Date signed \_\_\_\_\_

**For Bureau Use Only**

Received in Bureau

# EMT License Renewal Education Record

Candidate Name: \_\_\_\_\_

Each license cycle, an EMT must complete:

- A minimum of 48 hours of continuing education (CE)
- A minimum of four (4) venues (at least one (1) hour in each)
  - **Transition Education was 75% (at least 36 hours) of this license cycle exempting me from the venue requirement** Yes\_\_\_ No\_\_\_
- A minimum ten (10) categories
  - Pediatric assessment and management must be one of the categories with a minimum of four (4) hours
  - EMS Systems and Operations must be one the categories with a minimum of three (3) hours, including an LZO and extrication awareness course

		Venues										Total hours in each Category (add across)
		Structured classroom sessions	Refresher programs that revisit original curriculum and have an evaluation component	Nationally recognized courses	Regional and national conferences	Teaching topical material	Agency Medical Director approved self-study or directed study	Case reviews and grand rounds	Formal distance learning	Journal article review with an evaluation instrument	Author or co-author an EMS related article in a nationally recognized publication	
Categories	Pediatric assessment and management ( <i>4 hrs required</i> )											
	EMS systems and operations ( <i>3 hours required for LZO and Extrication Awareness</i> )											
	○ <b>Must have a minimum of four (4) hours per category in at least eight (8) of the remaining categories</b>											
	Anatomy and physiology											
	Medical terminology											
	Pathophysiology											
	Life span development											
	Public health											
	Pharmacology											
	Airway management											
	Assessment											
	Medical conditions											
	Shock and resuscitation											
	Trauma											
	Special patient populations											
<b>TOTAL HOURS</b>												

**During this license cycle, I have completed and documented the following:**

**Extrication Awareness:** ☐ EMS Bureau Learning Management System, or ☐ an EST Certificate Yes\_\_\_ No\_\_\_ **Date:** \_\_\_\_\_

**Landing Zone Officer (LZO) training:** ☐ Distributed learning, or ☐ Classroom Yes\_\_\_ No\_\_\_ **Date:** \_\_\_\_\_

I certify that the information I have provided within this document including any attached supplemental information is true, complete and correct. I further understand that failing to disclose information or falsification of information may be punishable by prosecution for perjury pursuant to Section 18-5401, Idaho Code. I understand that this submission may be audited and I may be expected to produce valid documentation supporting the information I have submitted. Violations of IDAPA 16.01.12.10, "Falsification of Applications or Reports" may result in an EMS license denial, refusal to renew, suspension, or revocation.

\_\_\_\_\_  
Candidate signature

\_\_\_\_\_  
Date

## EMT Skills Verification

Candidate Name: \_\_\_\_\_

As the Physician Medical Director for the above named EMS Agency, I attest that this license renewal candidate has demonstrated proficiency in the skills and knowledge necessary to provide safe and effective patient care at the EMT license level and in the recognition and management of traumatic injuries and medical life threats or conditions for the pediatric, adult, geriatric and special needs populations. Furthermore, I attest to the competency of this candidate in all skills and interventions within the “floor” of the Idaho EMS Physician Commission Scope of Practice that includes:

- Airway, ventilation, and oxygenation
- Cardiovascular and circulation
- Immobilization
- Medication administration
- Normal and complicated childbirth
- Patient care reporting documentation and
- Safety and transport operations.

Is the scope of practice for this license renewal candidate restricted as a result of failure to meet or maintain proficiencies?    Yes    No

If Yes, please provide details:

\_\_\_\_\_  
Signature of MD

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

If the Medical Director would like to appoint a designee for skills verification at the EMR and EMT level, please fill out the Medical Director Skills Verification Delegation of Signature Authority form. This document is located on the EMS Bureau website at [www.idahoems.org](http://www.idahoems.org) under Provider Licensure forms.

If you have completed your Transition Course and desire to transition your license to the new curriculum level, please submit this form with your renewal application.



## ***EMS Personnel License Transition Application***

### ***Idaho Emergency Medical Services Bureau***

Send completed form to: Idaho EMS Bureau, PO Box 83720, Boise, ID 83720-0036 or  
Fax to: 208-334-4015 or Email to: [EMSProvLic@dhw.idaho.gov](mailto:EMSProvLic@dhw.idaho.gov)



**Level Applying For:** ☐ Emergency Medical Responder (EMR) 2011 ☐ Emergency Medical Technician (EMT) 2011

SSN –or– EMS License # \_\_\_\_\_

Name \_\_\_\_\_  
Last Name First Name Middle Name

Transition Course # \_\_\_\_\_

Transition Education was completed within one (1) license duration (36 months) Yes\_\_\_ No\_\_\_ Date From: \_\_\_\_\_ To: \_\_\_\_\_

I hereby affirm the information herein is true and correct, and that I meet all requirements for an updated EMS license as established by the State of Idaho.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date signed